

## 2074 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Kent</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>New Hampshire</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Winchester</b> ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Kent &amp; Queen Annes</b>		d. STREET ADDRESS <b>45 Mechanic St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Geneva Caroline</b> First Middle Last		4. DATE OF DEATH <b>February 1</b> Month Day Year <b>58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 1, 1876</b> 81 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	9. AGE (In years last birthday) <b>81</b> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <b>New Hampshire</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Frank Hildreth</b>		14. MOTHER'S MAIDEN NAME <b>Ripley</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> If yes, give war or dates of service		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Hospital Records, Chestertown, Md.</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Bronchopneumonia</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>1 week</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>94.9 Fracture of right clavicle and severe fall</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>1/18</b> , 19 <b>58</b> to <b>2/1</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>2/1/58</b> , and that death occurred at <b>3:30 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Chestertown, Md.</b> DATE SIGNED			
ACTUAL SIGNATURE <b>Robert W. Farr</b> M.D. <b>Chestertown, Md.</b>			
PHYSICIAN'S NAME (Type) <b>ROBERT W. FARR</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Feb. 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Evergreen Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Winchester New Hampshire</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Willis Wells</b> ADDRESS <b>Chestertown, Md.</b>		24a. REC'D BY REGISTRAR <b>FEB 5 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Robert W. Farr</b>

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
John J. Jones		Male		45		October 1, 1875		Maryland		Baltimore, Md.		Pneumonia		October 1, 1915		10:00 AM		City of Baltimore		J. J. Jones		J. J. Jones	
Occupation		Married		Single		Widowed		Divorced		Never Married		Died at Home		Died in Hospital		Died in Prison		Died in Asylum		Died in Almshouse		Died in Other Institution	
John J. Jones		Yes		No		No		No		No		Yes		No		No		No		No		No	
Name of Physician		Name of Hospital		Name of Prison		Name of Asylum		Name of Almshouse		Name of Other Institution		Name of Registrar		Name of Physician		Name of Registrar		Name of Physician		Name of Registrar		Name of Physician	
J. J. Jones		City of Baltimore		City of Baltimore		City of Baltimore		City of Baltimore		City of Baltimore		J. J. Jones		J. J. Jones		J. J. Jones		J. J. Jones		J. J. Jones		J. J. Jones	

RECEIVED  
FEB 5 1916  
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2075

## CERTIFICATE OF DEATH

12064

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Kent</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b>		c. LENGTH OF STAY IN life <b>37</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>333 Cannon St.</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>C.</b> Last <b>Chambers</b>		4. DATE OF DEATH <b>Feb. 6, 1958</b> Day <b>19</b> Year	
5. SEX <b>female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 4, 1889</b>
9. AGE (In years last birthday) <b>68</b> yrs.		IF UNDER 1 YEAR Months <b>68</b> Days <b>68</b> Hours <b>68</b> Min.	IF UNDER 24 HRS. Months <b>68</b> Days <b>68</b> Hours <b>68</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife and</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Laborer</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Perry Dudley</b>		14. MOTHER'S MAIDEN NAME <b>Arminthia Darkus</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>216-07-6523</b>	
17. INFORMANT <b>George Geo. Chambers</b>		Address <b>Chestertown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Widespread Metastasis</b> DUE TO <b>157x</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of Pancreas</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>3 months</b> <b>2 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <b>19</b> Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Oct 57</b> , 19 <b>57</b> , to <b>Feb 6</b> , 19 <b>58</b> that I last saw the deceased alive on <b>Feb 6</b> , 19 <b>58</b> , and that death occurred at <b>3 P</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Thomas J. Solon</b>		DATE SIGNED <b>Feb. 6, 1958</b>	
PHYSICIAN'S NAME (Type) <b>Thomas J. Solon</b>		ADDRESS <b>Chestertown, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Feb. 9 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Fairlee (col. Cem.)</b>	22d. LOCATION (City, town, or county) (State) <b>near Chestertown, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Kenneth Waller</b>		ADDRESS <b>Chestertown, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>FEB 10 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Chambers</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 10 1958

RECEIVED

2076 CERTIFICATE OF DEATH

02065

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Kent</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>37 Chestertown</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Sarah</b> Middle <b>Coppage</b> Last <b>Coppage</b>				4. DATE OF DEATH Month <b>February</b> Day <b>27</b> Year <b>1958</b>			
5. SEX <b>Fem.</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 14, 1872</b>	
9. AGE (In years last birthday) <b>85</b> yrs.		IF UNDER 1 YEAR Months <b>27</b> Days <b>19</b> Hours <b>8</b> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Music Teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>J. Frank Coppage</b>				14. MOTHER'S MAIDEN NAME <b>Eliza Jane McFadden</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Fred Seney--Chestertown, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>450.0 Congestive Heart Failure</b> DUE TO <b>Arterio Sclerotic Vascular Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>450.0</b> DUE TO (c) <b>450.0</b>						INTERVAL BETWEEN ONSET AND DEATH <b>4 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March</b> , 19 <b>54</b> , to <b>Feb. 27</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Feb. 27</b> , 19 <b>58</b> , and that death occurred at <b>2 P.</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Robert W. Farrar</b>				ADDRESS (Street, city or town, state) <b>Chestertown, Md.</b>		DATE SIGNED <b>3/1/58</b>	
PHYSICIAN'S NAME (Type) <b>Robert W. Farrar M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Mar. 2</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Church Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Church Hill, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edgar L. Lane</b>				ADDRESS <b>Church Hill, Maryland</b>		24a. REC'D BY REGISTRAR <b>DATE MAR 5 1958</b>	
				24b. REGISTRAR'S SIGNATURE <b>Edgar L. Lane</b>			

MEDICAL CERTIFICATION

TO HOSPITAL ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1958 5 MAR

RECEIVED



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2077 CERTIFICATE OF DEATH

02066

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>KENT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>KENT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHESTERTOWN</u>				c. LENGTH OF STAY IN 1b <u>10 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>KENT &amp; QUEEN ANNE'S HOSP</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>GEORGE</u> Middle <u>BROWN</u> Last <u>FARR</u>				4. DATE OF DEATH Month <u>FEB</u> Day <u>26</u> Year <u>1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-31-83</u>	9. AGE (In years last birthday) <u>74</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RET.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Store</u>		11. BIRTHPLACE (State or foreign country) <u>N.Y.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>JOHN FARR</u>			
14. MOTHER'S MAIDEN NAME <u>HARRIETT CHANDLER</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>LINK</u> no			
16. SOCIAL SECURITY NO. <u>214-28-3758</u>				17. INFORMANT <u>HOSP. CHART</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MESENTERIC THROMBOSIS</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>GENERALIZED ARTERIOSCLEROSIS</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>2-23</u> , 19 <u>58</u> , to <u>2-26</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>2-25</u> , 19 <u>58</u> , and that death occurred at <u>5 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>CHESTERTOWN, Md.</u> DATE SIGNED <u>2-26-58</u> ACTUAL SIGNATURE <u>G. J. Keefe</u> M.D. PHYSICIAN'S NAME (Type) <u>A. T. KEEFE, JR. M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Feb. 28, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Chester Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Chestertown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Willis Wells</u> ADDRESS <u>Chestertown, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 28 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Willis Wells</u>	

BUREAU V. S.

FEB 28 1953

RECEIVED



## 2078 CERTIFICATE OF DEATH

Reg. Dist. No. 02067

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Kent</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>		c. LENGTH OF STAY IN 1b <u>10 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kent + Queen Annes Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Fawn</u> Middle <u>Reith</u> Last <u>Farrow</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>19</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-9-1958</u>
9. AGE (In years last birthday) yrs. <u>10</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>10</u> Days <u>10</u> Hours <u>10</u> Min. <u>10</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Gilbert Farrow</u>		14. MOTHER'S MAIDEN NAME <u>Dorothy Harrington</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Ms. Gilbert Farrow</u>	
17. INFORMANT <u>Chestertown MD</u>		Address <u>Chestertown MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> DUE TO <u>773.5</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Premature Birth</u> DUE TO (c) <u>Birth 10 days old</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Intermittent</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Wgt on Birth about 11b9oz</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2/9</u> , 19 <u>58</u> , to <u>Feb 19</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Feb 19</u> , 19 <u>58</u> , and that death occurred at <u>10A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas J. Solow</u>		DATE SIGNED <u>2/19/58</u>	
PHYSICIAN'S NAME (Type) <u>Thomson J. Solow</u>		M.D. <u>Chestertown, MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-21-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Banquet Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Fredens - Soda</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Millard Carper</u>		ADDRESS <u>Hgtn. Del.</u>	
24a. REC'D BY REGISTRAR <u>2072353XVV</u>		24b. REGISTRAR'S SIGNATURE <u>DATE FEB 24 '58</u>	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. E.

FEB 24 1958

RECEIVED

2087

## CERTIFICATE OF DEATH

02068

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Worton</u>		c. LENGTH OF STAY IN 1b <u>Lifetime</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>00</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Sylvester Graves</u>		4. DATE OF DEATH Month Day Year <u>February 27 19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Unknown 1875</u>
9. AGE (In years last birthday) <u>82</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Henry Graves</u>		14. MOTHER'S MAIDEN NAME <u>Edith Washington</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	17. INFORMANT Address <u>Charles Graves Worton, R.F.D. Md.</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio sclerotic vascular disease</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>4 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Coronary occlusion</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June</u> , 19 <u>56</u> , to <u>Feb. 27</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>2/27</u> , 19 <u>58</u> , and that death occurred at <u>9:00A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Chestertown, Md.</u> DATE SIGNED <u>2/27/58</u> ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>[Signature]</u> PHYSICIAN'S NAME (Type) <u>Robert W. Farr</u> <u>Chestertown, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/1/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Cemty</u>	22d. LOCATION (City, town, or county) (State) <u>Still Pond Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Victor N. Kennedy</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 28 '58</u>	24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in only event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
JAMES H. HARRIS		MALE		45		JAN 15 1893	
PLACE OF BIRTH		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
BALTIMORE, MD.		LABORER		HEART DISEASE		NATURAL	
DATE OF DEATH		PLACE OF DEATH		CERTIFICATE NO.		REGISTRATION NO.	
FEB 28 1938		BALTIMORE, MD.		12345		67890	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	
DATE		PLACE		CAUSE		MANNER	
FEB 28 1938		BALTIMORE, MD.		HEART DISEASE		NATURAL	

Walter B. Kennedy

RECEIVED

FEB 28 1938

BUREAU W. S.

Reg. Dist. No.

**TO HOSPITAL:** [redacted] **ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/55

1. PLACE OF DEATH a. COUNTY <u>KENT</u>		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>KENT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MILLINGTON</u>		c. LENGTH OF STAY IN 1b <u>X</u> <u>MILLINGTON</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MARTHA</u> First <u>HARRIS</u> Middle <u>HARRIS</u> Last		4. DATE OF DEATH Month <u>FEB.</u> Day <u>23</u> Year <u>1958</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>COL.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC. 14, 1873</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WORK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>RICHARD ROBINSON</u>		14. MOTHER'S MAIDEN NAME <u>TEMPE COTTON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>THEODORE HARRIS</u>		Address <u>MILLINGTON, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Arteritis</u> DUE TO (c) <u>Senility</u> INTERVAL BETWEEN ONSET AND DEATH <u>18-15 years</u> <u>20 years</u> <u>D.I.C.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>no injury</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>no injury</u>	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept 5</u> , 19 <u>57</u> , to <u>Feb 23</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Feb 22</u> , 19 <u>58</u> , and that death occurred at <u>1:45 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Millington Md</u> DATE SIGNED <u>2/26/58</u> ACTUAL SIGNATURE <u>H. H. Hamilton</u> M.D. PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>2/27/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>JESUAH CHAPEL CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>CHESTERTOWN, RURAL MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Fellows</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 3 '58</u>	
ADDRESS <u>Millington, Md</u>		24b. REGISTRAR'S SIGNATURE <u>W. Deauch</u>	

BUREAU V. S.

1958

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2089

## CERTIFICATE OF DEATH

Reg. Dist. No.

02070

1. PLACE OF DEATH a. COUNTY <u>Kent</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hall</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hall</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Walter Jewell Hepbron</u>		4. DATE OF DEATH Month Day Year <u>February 11 19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>July 13, 1900</u>
9. AGE (In years last birthday) yrs. <u>57</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Harry H. Hepbron</u>	
14. MOTHER'S MAIDEN NAME <u>Larry Jewell</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>216-30-7144</u>		17. INFORMANT Address <u>Mr. Percy Hepbron--Rock Hall, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Arteriosclerosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c) <u>Arterio Sclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Feb 9-</u> , 19 <u>58</u> , to <u>Feb 11-</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Feb 11-</u> , 19 <u>58</u> , and that death occurred at <u>6 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Norbert C. Mitsch</u> M.D. <u>Rock Hall Md</u> PHYSICIAN'S NAME (Type) <u>NORBERT-C-MITSCH</u> <u>ROCK-HALL MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Removal</u>	<u>Feb. 14</u>	<u>Wesley Chapel</u>	<u>Rock Hall, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar H. Lane</u>		ADDRESS <u>Church Hill, Md.</u>	24a. REC'D BY REGISTRAR DATE <u>FEB 18 '58</u>
		24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>	

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: The low requires that the death certificate be executed within 24 hours after death. Page 4

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
John Doe		45		Male		White		Jan 15 1910		New York City	
MARRIAGE		DATE OF MARRIAGE		PLACE OF MARRIAGE		NAME OF SPOUSE		DATE OF DEATH		PLACE OF DEATH	
Married		Jan 20 1935		New York City		Jane Doe		Feb 18 1958		Baltimore, Md.	
OCCUPATION		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE NO.	
Teacher		Feb 18 1958		Baltimore, Md.		Heart Disease		Natural		12345	
PREVIOUS ILLNESS		DATE OF PREVIOUS ILLNESS		PLACE OF PREVIOUS ILLNESS		NAME OF PHYSICIAN		DATE OF EXAMINATION		PLACE OF EXAMINATION	
None		None		None		None		None		None	
SIGNATURE OF DECEASED		SIGNATURE OF SPOUSE		SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	

BUREAU V. 8

FEB 18 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2079 CERTIFICATE OF DEATH

Reg. Dist. No.

02071

1. PLACE OF DEATH a. COUNTY <b>Kent</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b>		c. LENGTH OF STAY IN IB <b>1 day</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <b>Joshua First David Hopkins Last</b>		4. DATE OF DEATH <b>Feb. 10, 1958</b> Day Month Year	
5. SEX <b>male</b>	6. COLOR OR RACE <b>colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 9, 1942</b>
9. AGE (In years last birthday) <b>15 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Laurence Hopkins</b>		14. MOTHER'S MAIDEN NAME <b>Minnie Sisco</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>no</b>	
17. INFORMANT <b>Laurence Hopkins</b>		Address <b>Rock Hall, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Corniac Arrest</b> <b>754.5</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pulmonary Effusion, Congestive Failure</b> DUE TO (c) <b>Congenital Heart Disease</b>			INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>Chronic Since Birth</b> <b>Since Birth</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>2/10</b> , 19 <b>58</b> , to <b>2/10</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>2/10</b> , 19 <b>58</b> , and that death occurred at <b>4:10 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Chestertown, Maryland</b> DATE SIGNED <b>2/10/58</b>			
ACTUAL SIGNATURE <b>Thomas J. Solon</b>		M.D. <b>Chestertown, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>Thomas J. Solon, M.D.</b>		<b>Chestertown, Kent Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Feb. 14, 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Sharptown (Col.)</b>	22d. LOCATION (City, town, or county) (State) <b>Rock Hall, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Kenneth Wallay</b>		ADDRESS <b>Chestertown, Md.</b>	
24a. REC'D BY REGISTRAR <b>FEB 13 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Qu. Lewis</b>	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1958 FEB 13

RECEIVED

## Reg. Dist. No.

MEDICAL CERTIFICATION

VS A15 (4)  
15M 9/55

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION		6. PLACE OF BIRTH	
JAMES M. JONES		Male		35		White		Teacher		Maryland	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF PHYSICIAN	
Jan 10, 1958		10:00 AM		Home		Heart Disease		Natural		J. M. Jones	
13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESSES		15. SIGNATURE OF FUNERAL HOME		16. SIGNATURE OF MINISTER		17. SIGNATURE OF CLERGY		18. SIGNATURE OF OTHER	
J. M. Jones		J. M. Jones		J. M. Jones		J. M. Jones		J. M. Jones		J. M. Jones	

BUREAU V. 2

FEB 10 1958

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02073

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Kent</b> <span style="float: right;">MARYLAND</span>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown - rural</b>		c. LENGTH OF STAY IN 1b <b>plus 3 years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>James</b> Middle <b>Henry</b> Last <b>Johnson</b>		<b>4. DATE OF DEATH</b> Month <b>2</b> Day <b>17</b> Year <b>1958</b>	
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>Colored</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>1885</b>
<b>9. AGE</b> (In years last birthday) <b>72 yrs.</b>		<b>IF UNDER 1 YEAR</b> <b>IF UNDER 24 HRS.</b> Months      Days      Hours      Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>laborer</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Various</b>	
<b>11. BIRTHPLACE</b> (State or foreign country) <b>Virginia</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA-</b>	
<b>13. FATHER'S NAME</b> <b>Unknown</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Unknown</b>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (If yes, no, or unknown) <b>Unknown</b>		<b>16. SOCIAL SECURITY NO.</b> <b>213-24-1246</b>	
<b>17. INFORMANT</b> <b>Jane Tiller</b>		Address <b>Rt D. 1 Chestertown, Md.</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Unknown, probable stroke or heart attack</b> 334X <b>Deceased had a stroke about 2 yrs ago. He was apparently and ate supper 2/16/58 &amp; went up to bed. He was found dead 1:00A.M. the next day.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>but</b> DUE TO <b>dead 1:00A.M. the next day.</b> (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hemiplegia - 2 years</b>			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> CAUSE OF DEATH.	
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)		<b>20c. TIME OF INJURY</b> Month, Day, Year Hour      o. m.      p. m.      19	
<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	
<b>20f. (City or town)</b> (County)      (State)		<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input checked="" type="checkbox"/>	
<b>ACTUAL SIGNATURE</b> <b>Robert W. Farr, M. D.</b>		<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>	
<b>EXAMINER'S NAME (Type)</b>		<b>DATE SIGNED</b> <b>2/20/58</b>	
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>2/23/58</b>	
<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Morgnac (Col.) Cem.</b>		<b>22d. LOCATION (City, town, or county)</b> (State) <b>Near - Chestertown, Md.</b>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>J. Willis Wells</b>		<b>ADDRESS</b> <b>Chestertown, Md.</b>	
<b>24a. RECEIVED BY REGISTRAR</b> <b>DATE</b> <b>FEB 25 '58</b>		<b>24b. REGISTRAR'S SIGNATURE</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE DEPARTMENT OF HEALTH—BIRMINGHAM  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

FEB 25 1958

RECEIVED

## 2081 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Kent</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b>				c. LENGTH OF STAY IN 1b <b>2 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kent &amp; Calvert St.</b>				d. STREET ADDRESS <b>1 Kent &amp; Calvert St.</b>			
3. NAME OF DECEASED (Type or print) First <b>Harry</b> Middle <b>Elmer</b> Last <b>Johnson</b>				4. DATE OF DEATH Month <b>Feb.</b> Day <b>17</b> Year <b>19 58</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 20, 1869</b>		9. AGE (In years last birthday) <b>88 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer Ret.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>TENANT</b>		11. BIRTHPLACE (State or foreign country) <b>Penna</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Jacob Johnson</b>				14. MOTHER'S MAIDEN NAME <b>Hannah Marjarum</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>I6I-I4-8623</b>		17. INFORMANT <b>Horace Johnson</b> Address <b>Chestertown Kent &amp; Calvert Sts.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Damage</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary insufficiency</b> DUE TO (c) <b>atherosclerosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>7 yrs</b> <b>years</b> <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Prostatic Obstruction</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <b>19</b> Month, Day, Year p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from <b>Feb. 27</b> , 19 <b>57</b> , to <b>Feb 16</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Feb 17</b> , 19 <b>58</b> , and that death occurred at <b>2:30 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <b>Thomas J. Solon</b> M.D. <b>Chestertown, Md.</b> PHYSICIAN'S NAME (Type) <b>Thomas J. Solon</b> <b>Chestertown, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 21, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Wm. Penn Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Somerton, Penna.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Willis Wells</b> ADDRESS <b>Chestertown, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>FEB 20 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. Beach</b>	

MEDICAL CERTIFICATION

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

FEB 20 1958

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2091

## CERTIFICATE OF DEATH

Reg. Dist. No. 02075

1. PLACE OF DEATH o. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millington Rural		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural Millington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) Mary First Middle Last Kantor		4. DATE OF DEATH Feb. 27 Day 19 53 Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 24, 1895
9. AGE (In years lost birthday) 62 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY home	11. BIRTHPLACE (State or foreign country) Hungary
12. CITIZEN OF WHAT COUNTRY? U.S.A		13. FATHER'S NAME Tony Matches	
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) None	
16. SOCIAL SECURITY NO. None		17. INFORMANT Mary Reed 1531 Bush St. Address Baltimore Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) apoplexy DUE TO (c) hypertension INTERVAL BETWEEN ONSET AND DEATH 5 days one year 2			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE J. J. Koralowski M.D.		PHYSICIAN'S NAME (Type) DR. GEZA KORALEWSKI MILLINGTON, MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF March 3, 1958	22c. NAME OF CEMETERY OR CREMATORY St. Dennis Cem.	22d. LOCATION (City, town, or county) (State) Rural Galena Md.
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Edward Tellow Millington Md.		24a. REC'D BY REGISTRAR DATE MAR 5 '58	24b. REGISTRAR'S SIGNATURE

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 02076

1. PLACE OF DEATH a. COUNTY <b>Kent</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Chestertown</b> c. LENGTH OF STAY IN 1b <b>5 years</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Chestertown</b> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Donald</b> Middle <b>Keen</b> Last <b>Keen</b>		4. DATE OF DEATH <b>June 2/ 22 19 58</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 4, 1949</b>
9. AGE (In years last birthday) <b>8 yrs.</b>		IF UNDER 1 YEAR Months <b>8</b> Days <b>22</b> Hours <b>58</b> Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Rockville Centre, N. Y.</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Harry T. Keen</b>		14. MOTHER'S MAIDEN NAME <b>Patricia Hughes</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Herman Blackway, Chestertown, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Drowning</b> <b>Instantaneous</b> <b>929.8</b> <b>Was out walking about 2:00P.M. 2/22/58 and was missed by late afternoon. Search was made. The body was found under a hole in the ice on a branch of Lankford Bay. Death is presumed to have been caused by drowning.</b> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Probably fell through a hole in the ice.</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>afternoon 2/22 19 58</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Lankford Bay</b>		20f. (City or town) <b>Chestertown Kent, Md.</b> (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Robert W. Farr, M. D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Robert W. Farr, M. D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 25, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St Paul Cem.</b>		22d. LOCATION (City, town, or county) <b>near Chestertown, Md.</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Willis Wells</b>		ADDRESS <b>Chestertown, Md.</b>	
24a. REC'D BY REGISTRAR <b>FEB 26 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Deborah</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

MISSOURI STATE DEPARTMENT OF HEALTH—Baltimore, 18  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Race		Date of Death	
John Doe		Male		35		White		Jan 15, 1938	
Place of Birth		Cause of Death		Manner of Death		Occupation		Residence	
New York City		Heart Disease		Natural		Teacher		123 Main St, New York	
Date of Birth		Time of Death		Place of Death		Physician		Hospital	
Jan 1, 1903		10:30 AM		Home		Dr. Smith		St. Mary's	
Signature of Physician		Signature of Medical Examiner		Signature of Coroner		Signature of Registrar		Signature of Burial Officer	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

**RECEIVED**  
 FEB 26 1938  
 BUREAU V. S.

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2082 CERTIFICATE OF DEATH

Reg. Dist. No.

02077

1. PLACE OF DEATH a. COUNTY <b>Kent</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b>			c. LENGTH OF STAY IN 1b <b>1 day</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rock Hall</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kent &amp; Queen Annes</b>				d. STREET ADDRESS <b>Liberty</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>OSCAR</b> Last <b>McGINNIS</b>				4. DATE OF DEATH Month <b>Feb</b> Day <b>5</b> Year <b>19 58</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 12, 1898</b>		
9. AGE (In years last birthday) <b>59</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Garage</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Thomas McGinnis</b>				14. MOTHER'S MAIDEN NAME <b>Ella Lee Startt</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>216-10-3704</b>		17. INFORMANT <b>Hospital Rcds, Chestertown, Md.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary Sclerosis</b> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <b>15 hours</b>  <b>Don't know</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. <b>11</b> p. m. Month, Day, Year <b>19 58</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>2/4/58</b> , 19____, to <b>2/5/58/9</b> , that I last saw the deceased alive on <b>2/5/58</b> , 19____, and that death occurred at <b>12550A M.</b> from the causes and on the date stated above.								
ACTUAL SIGNATURE <b>Robert W. Farr</b>				ADDRESS (Street, city or town, state) <b>Chestertown, Md.</b>				
PHYSICIAN'S NAME (Type) <b>ROBERT W. FARR</b>				DATE SIGNED <b>Feb 5, 1958</b>				
22a. (BURIAL) CREMATION, REMOVAL (Specify) <b>Feb. 8, 1958</b>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <b>Wesley Chapel</b>		22d. LOCATION (City, town, or county) (State) <b>Rock Hall Md.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edgar L. Lane Church Hill, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>FEB 11 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Chas. Leach</b>		

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		45		M		W		JAN 15 1885		BALTIMORE, MD.	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH	
1234 E. BALTIMORE ST.		LABORER		HEART DISEASE		NATURAL		FEB 10 1933		BALTIMORE, MD.	
FAMILY PHYSICIAN		ATTENDING PHYSICIAN		PATHOLOGIST		BURIAL PLACE		DATE OF BURIAL		PLACE OF BURIAL	
DR. J. H. HARRIS		DR. J. H. HARRIS		DR. J. H. HARRIS		CATHOLIC CHURCH		FEB 11 1933		CATHOLIC CHURCH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES		SIGNATURE OF REGISTRAR		SIGNATURE OF CLERK		SIGNATURE OF JURY	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	

BUREAU V. S.

FEB 11 1933

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2083 CERTIFICATE OF DEATH

Reg. Dist. No. 02078

1. PLACE OF DEATH a. COUNTY <b>Kent</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chesterto wn</b>		c. LENGTH OF STAY IN 1b <b>7 days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Chestertown</b>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kent and Queen Anne's</b>		d. STREET ADDRESS <b>Fairlee</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Noble Walton</b> First Middle Last		4. DATE OF DEATH <b>February 3</b> Month Day Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Maryland 12-6-23</b>
9. AGE (In years last birthday) yrs. <b>34</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Automobile</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Noble H. Middleton</b>	
14. MOTHER'S MAIDEN NAME <b>Ethel Perry</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service <b>Yes WW II &amp; Korean</b>	
16. SOCIAL SECURITY NO. <b>220-26-3378</b>		17. INFORMANT <b>Hospital records-Chestertown, Md.</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Staphylococcic meningitis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Mastoiditis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>8 days</b> <b>12 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. j. p. m. Month, Day, Year <b>19 58</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>1-28-58</b> , 19 <b>58</b> to <b>2-3-58</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>2-3</b> , 19 <b>58</b> , and that death occurred at <b>12:10a</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Chestertown, Md.</b> DATE SIGNED <b>2-3-58</b>			
ACTUAL SIGNATURE <b>A.C. Dick</b>		PHYSICIAN'S NAME (Type) <b>A.C. Dick</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Feb. 5, 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Paul Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>near - Chestertown, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Willis Wells</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 5 58</b>	24b. REGISTRAR'S SIGNATURE <b>W. J. ...</b>

1958 21

**BUREAU K. S.**

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2081 CERTIFICATE OF DEATH

Reg. Dist. No. 02079

1. PLACE OF DEATH a. COUNTY <b>Kent</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Queen Annes</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sudlersville</b> <b>17X-3</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kent &amp; Queens Annes Hospital</b>				d. STREET ADDRESS <b>17X-3</b>			
3. NAME OF DECEASED (Type or print) First <b>Lelia</b> Middle <b>Paynter</b> Last <b>Paynter</b>				4. DATE OF DEATH Month <b>Feb</b> Day <b>28</b> Year <b>1958</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 18, 1885</b>		9. AGE (In years last birthday) <b>72</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Fletcher Sparks</b>				14. MOTHER'S MAIDEN NAME <b>Mary Reese</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>None</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>John R. Sparks Box 78 New Castle Del.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> DUE TO <b>600.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Terminal Nephritis</b> DUE TO <b>Pylitis &amp; cystitis</b> (c) <b>?</b>						INTERVAL BETWEEN ONSET AND DEATH <b>5 wks</b> <b>?</b> <b>5 wks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>19</b> to <b>Feb 28, 1958</b> , that I last saw the deceased alive on <b>Feb 28, 1958</b> , and that death occurred at <b>10 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Chestertown</b> DATE SIGNED <b>3/1/58</b>							
ACTUAL SIGNATURE <b>Thomas J. Solon</b>		PHYSICIAN'S NAME (Type) <b>THOMAS J. SOLON</b>		ADDRESS <b>Chestertown</b>		DATE SIGNED <b>MD</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/3/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Sudlersville Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Sudlersville Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edward Willow Mullington</b>				24a. REC'D BY REGISTRAR <b>DATE MAR 5 1958</b>		24b. REGISTRAR'S SIGNATURE <b>Quel...</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

## 2093 CERTIFICATE OF DEATH

02080

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Kent</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rock Hall</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rock Hall</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>00</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Charles A. Schuman</b>				4. DATE OF DEATH <b>Feb. 24 19 58</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 13, 1876</b>		9. AGE (In years last birthday) <b>81</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Automobiles</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles A. Schuman</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Eckert</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>214-28-8558</b>		17. INFORMANT <b>Charles H. Schuman</b> Address <b>Rock Hall, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb 21, 1958</b> , to <b>Feb 24, 1958</b> , that I last saw the deceased alive on <b>Feb 21, 1958</b> , and that death occurred at <b>3 P. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Rock Hall</b> DATE SIGNED <b>Dr. Kester</b>							
ACTUAL SIGNATURE <b>Dr. Kester</b> M.D. <b>Rock Hall</b>							
PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>Feb. 26</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Wesley Chapel</b>		22d. LOCATION (City, town, or county) (State) <b>Rock Hall Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edgar L. Lane</b> ADDRESS <b>Church Hill, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>FEB 28 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Beach</b>	

MEDICAL CERTIFICATION

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
JAMES EARL RAY		35		Male		White		May 22, 1928		Memphis, Tennessee		Tennessee		United States of America	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH	
May 14, 1968		St. Louis, Missouri		St. Louis, Missouri		United States of America		May 14, 1968		St. Louis, Missouri		St. Louis, Missouri		United States of America	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		MARRIAGE		SINGLE		MARRIED	
Suicide by gunshot		Suicide		Attorney		High School		Catholic		Married		Single		Married	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH	
May 14, 1968		St. Louis, Missouri		St. Louis, Missouri		United States of America		May 14, 1968		St. Louis, Missouri		St. Louis, Missouri		United States of America	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH	
May 14, 1968		St. Louis, Missouri		St. Louis, Missouri		United States of America		May 14, 1968		St. Louis, Missouri		St. Louis, Missouri		United States of America	

BUREAU V. 51

738 98 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2985 CERTIFICATE OF DEATH

Reg. Dist. No. 02081

1. PLACE OF DEATH a. COUNTY <b>KENT</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>KENT</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHESTERTOWN</b>				c. LENGTH OF STAY IN 1b <b>X RD 2 CHESTERTOWN</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>KENT QUEEN ANNE'S</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Scott</b> First <b>John W.</b> Middle <b>Scott</b> Last				4. DATE OF DEATH Month <b>2</b> Day <b>9</b> Year <b>1958</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEP. 9 1899</b>		9. AGE (In years last birthday) <b>58</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>WATCHMAN</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>at college</b>		11. BIRTHPLACE (State or foreign country) <b>U.S. MARYLAND</b>	
13. FATHER'S NAME <b>WM JOSEPH SCOTT</b>				14. MOTHER'S MAIDEN NAME <b>ADDIE BOULTER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>217-16-9155</b>		17. INFORMANT Address <b>Mrs. Ada Scott (wife) Chestertown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cornary Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>none</b> (c) <b>none</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>				
20c. TIME OF INJURY Hour a. <b>11</b> p. m. Month, Day, Year <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
			20f. (City or town)		(County) (State)		
21. I certify that I attended the deceased from <b>2-9-58</b> , 19 <b>58</b> , to <b>2-9-58</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>2-9-58</b> , 19 <b>58</b> , and that death occurred at <b>3:05 A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Manfred Gerstley</b>				ADDRESS (Street, city or town, state) <b>212 CAMPUS AVE</b>		DATE SIGNED <b>2/19/58</b>	
PHYSICIAN'S NAME (Type) <b>MANFRED J. GERSTLEY</b>				<b>CHESTERTOWN - MD</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. II, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Wesley Chapel Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Rock Hall, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Willis Wells</b>				ADDRESS <b>Chestertown, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 11 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>W. H. ...</b>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH	
5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. COLOR	
9. PLACE OF DEATH		10. CAUSE OF DEATH		11. MEDICAL HISTORY		12. SIGNATURE OF PHYSICIAN	
13. SIGNATURE OF CORONER		14. SIGNATURE OF WITNESSES		15. SIGNATURE OF DECEASED		16. SIGNATURE OF FUNERAL HOME	
17. SIGNATURE OF BURIAL SOCIETY		18. SIGNATURE OF CHURCH		19. SIGNATURE OF CEMETERY		20. SIGNATURE OF OTHER	
21. SIGNATURE OF STATE DEPARTMENT OF HEALTH		22. SIGNATURE OF COUNTY DEPARTMENT OF HEALTH		23. SIGNATURE OF CITY DEPARTMENT OF HEALTH		24. SIGNATURE OF DISTRICT DEPARTMENT OF HEALTH	
25. SIGNATURE OF TOWNSHIP DEPARTMENT OF HEALTH		26. SIGNATURE OF WARD DEPARTMENT OF HEALTH		27. SIGNATURE OF BLOCK DEPARTMENT OF HEALTH		28. SIGNATURE OF OTHER	
29. SIGNATURE OF OTHER		30. SIGNATURE OF OTHER		31. SIGNATURE OF OTHER		32. SIGNATURE OF OTHER	
33. SIGNATURE OF OTHER		34. SIGNATURE OF OTHER		35. SIGNATURE OF OTHER		36. SIGNATURE OF OTHER	
37. SIGNATURE OF OTHER		38. SIGNATURE OF OTHER		39. SIGNATURE OF OTHER		40. SIGNATURE OF OTHER	
41. SIGNATURE OF OTHER		42. SIGNATURE OF OTHER		43. SIGNATURE OF OTHER		44. SIGNATURE OF OTHER	
45. SIGNATURE OF OTHER		46. SIGNATURE OF OTHER		47. SIGNATURE OF OTHER		48. SIGNATURE OF OTHER	
49. SIGNATURE OF OTHER		50. SIGNATURE OF OTHER		51. SIGNATURE OF OTHER		52. SIGNATURE OF OTHER	
53. SIGNATURE OF OTHER		54. SIGNATURE OF OTHER		55. SIGNATURE OF OTHER		56. SIGNATURE OF OTHER	
57. SIGNATURE OF OTHER		58. SIGNATURE OF OTHER		59. SIGNATURE OF OTHER		60. SIGNATURE OF OTHER	
61. SIGNATURE OF OTHER		62. SIGNATURE OF OTHER		63. SIGNATURE OF OTHER		64. SIGNATURE OF OTHER	
65. SIGNATURE OF OTHER		66. SIGNATURE OF OTHER		67. SIGNATURE OF OTHER		68. SIGNATURE OF OTHER	
69. SIGNATURE OF OTHER		70. SIGNATURE OF OTHER		71. SIGNATURE OF OTHER		72. SIGNATURE OF OTHER	
73. SIGNATURE OF OTHER		74. SIGNATURE OF OTHER		75. SIGNATURE OF OTHER		76. SIGNATURE OF OTHER	
77. SIGNATURE OF OTHER		78. SIGNATURE OF OTHER		79. SIGNATURE OF OTHER		80. SIGNATURE OF OTHER	
81. SIGNATURE OF OTHER		82. SIGNATURE OF OTHER		83. SIGNATURE OF OTHER		84. SIGNATURE OF OTHER	
85. SIGNATURE OF OTHER		86. SIGNATURE OF OTHER		87. SIGNATURE OF OTHER		88. SIGNATURE OF OTHER	
89. SIGNATURE OF OTHER		90. SIGNATURE OF OTHER		91. SIGNATURE OF OTHER		92. SIGNATURE OF OTHER	
93. SIGNATURE OF OTHER		94. SIGNATURE OF OTHER		95. SIGNATURE OF OTHER		96. SIGNATURE OF OTHER	
97. SIGNATURE OF OTHER		98. SIGNATURE OF OTHER		99. SIGNATURE OF OTHER		100. SIGNATURE OF OTHER	

BUREAU V. E.

FEB 11 1959

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL HOME: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02082

## 2994 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Kent</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kennedyville</b>		c. LENGTH OF STAY IN 1b <b>11 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kennedyville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MARY</b> <b>BELLE</b> <b>SMITH</b>				4. DATE OF DEATH Month <b>February</b> Day <b>22</b> Year <b>19 58</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 29, 1872</b>		9. AGE (In years lost birthday) yrs. <b>85</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William E. Sparks</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Augusta Sparks</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Mrs. Adda Bond, Kennedyville, Md. (daughter)</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY THROMBOSIS</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <b>CORONARY ARTERIOSCLEROSIS</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>7 hours</b> <b>11-12 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. <b>9.</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>August 15, 1956</b> , to <b>February 22, 1958</b> , that I last saw the deceased alive on <b>February 22, 1958</b> , and that death occurred at <b>11:40A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Chestertown, Md.</b> DATE SIGNED <b>February 22, 1958</b>							
ACTUAL SIGNATURE <b>Robert W. Farr</b>		M.D. <b>ROBERT W. FARR, M.D.</b>					
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/25/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Riverview Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Wilmington Delaware</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Albert J. McCarty</b>				24a. REC'D BY REGISTRAR <b>2700 Washington St. Wilmington Delaware</b>		24b. REGISTRAR'S SIGNATURE <b>Feb 25 '58</b>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2095 CERTIFICATE OF DEATH

Reg. Dist. No. 02083

1. PLACE OF DEATH a. COUNTY <u>KENT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>KENT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETTERTON</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETTERTON</u>			
c. LENGTH OF STAY IN 1b <u>33 years</u>				d. STREET ADDRESS <u>—</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>SARAH</u> First <u>ELLEN</u> Middle <u>STONE</u> Last				4. DATE OF DEATH <u>FEB</u> Month <u>28</u> Day <u>1958</u> Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 14, 1866</u>	
9. AGE (In years last birthday) <u>91</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>HANLEY, ENGLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>JESSE ASH</u>				14. MOTHER'S MAIDEN NAME <u>HANNAH TOFT</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT <u>EARLE STONE</u>		Address <u>BETTERTON, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>uremia</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>generalized arteriosclerosis</u> DUE TO (c) <u>2 weeks</u> <u>2 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>MAY</u> , 19 <u>53</u> , to <u>FEB 28</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>FEB 26</u> , 19 <u>58</u> , and that death occurred at <u>9 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Worton, MD</u> DATE SIGNED <u>2/28/58</u> ACTUAL SIGNATURE <u>Florence Deringer-Joyce</u> M.D. <u>Worton, MD</u> PHYSICIAN'S NAME (Type) <u>FLORENCE DERINGER-JOYCE</u> <u>WORTON MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/3/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>LOUDEN PARK CEMT</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Victor H. Kennedy</u> ADDRESS <u>STILL POND, MD.</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 3 '58</u>		24b. REGISTRAR'S SIGNATURE <u>DeLoach</u>	

CERTIFICATE OF DEATH

Form with fields for Name, Age, Sex, Race, Cause of Death, and other medical details. The form is mostly blank with some faint markings.

Home

BUREAU V. S.  
3/28/28  
MAR 3 1928

RECEIVED

BURIAL 3/28/28 GOLDEN PARK CEMT BALTIMORE  
DISTRICT 1, ST. PETER, MD.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2086 CERTIFICATE OF DEATH

Reg. Dist. No. 02084

<b>1. PLACE OF DEATH</b> a. COUNTY <span style="margin-left: 100px;">Kent</span> <span style="margin-left: 100px;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <span style="margin-left: 20px;">Maryland</span> b. COUNTY <span style="margin-left: 20px;">Kent</span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <span style="margin-left: 40px;">Chestertown</span>		c. LENGTH OF STAY IN 1b <span style="margin-left: 40px;">1 day</span>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <span style="float: right;">✓</span> <span style="margin-left: 20px;">X Worton RFD</span>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <span style="margin-left: 40px;">Kent &amp; Queen Anne Hosp.</span>				d. STREET ADDRESS <span style="margin-left: 40px;">RFD Bigswood</span>			
<b>3. NAME OF DECEASED</b> (Type or print) <span style="margin-left: 40px;">First Kevin</span> <span style="margin-left: 40px;">Middle</span> <span style="margin-left: 40px;">Last Tiller</span>				<b>4. DATE OF DEATH</b> <span style="margin-left: 20px;">2/14/58</span> <span style="margin-left: 20px;">Month</span> <span style="margin-left: 20px;">Day</span> <span style="margin-left: 20px;">Year</span> <span style="margin-left: 40px;">19</span>			
<b>5. SEX</b> <span style="margin-left: 20px;">male</span>	<b>6. COLOR OR RACE</b> <span style="margin-left: 20px;">colored</span>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>B. DATE OF BIRTH</b> <span style="margin-left: 20px;">Mar 10, 1957</span>		<b>9. AGE</b> (In years last birthday) yrs. <span style="margin-left: 20px;">IF UNDER 1 YEAR</span> <span style="margin-left: 20px;">IF UNDER 24 HRS.</span> <span style="margin-left: 40px;">Month</span> <span style="margin-left: 20px;">Days</span> <span style="margin-left: 20px;">Hours</span> <span style="margin-left: 20px;">Min.</span>		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="margin-left: 40px;">none</span>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <span style="margin-left: 40px;">Kent Co. Md.</span>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <span style="margin-left: 40px;">USA</span>			
<b>13. FATHER'S NAME</b> <span style="margin-left: 40px;">Garven Potts</span>			<b>14. MOTHER'S MAIDEN NAME</b> <span style="margin-left: 40px;">Edith Tiller</span>				
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <span style="margin-left: 20px;">no</span>		<b>16. SOCIAL SECURITY NO.</b> <span style="margin-left: 40px;">no</span>		<b>17. INFORMANT</b> <span style="margin-left: 20px;">Address</span> <span style="margin-left: 40px;">Edith Tiller Worton, Md. RFD</span>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <span style="margin-left: 20px;">Circulatory collapse.</span> <span style="margin-left: 40px;">340.0</span> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <span style="margin-left: 20px;">Spinal meningitis (Hemophilus)</span> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <span style="margin-left: 20px;">6 hours</span> <span style="margin-left: 20px;">3 Wks</span>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <span style="margin-left: 20px;">Anemia</span>					<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>		
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> a. h. <span style="margin-left: 20px;">19</span> p. m.	<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> <span style="margin-left: 20px;">(County)</span> <span style="margin-left: 20px;">(State)</span>			
<b>21. I certify that I attended the deceased from</b> <span style="margin-left: 20px;">2/12</span> , 1958, to <span style="margin-left: 20px;">2/14</span> , 1958, that I last saw the deceased alive on <span style="margin-left: 20px;">2/14</span> , 1958, and that death occurred at <span style="margin-left: 20px;">10 A. M.</span> , from the causes and on the date stated above.							
<b>ACTUAL SIGNATURE</b> <span style="margin-left: 20px;">Thomas J. Solon</span> <span style="margin-left: 20px;">M.D.</span>				<b>ADDRESS</b> (Street, city or town, state) <span style="margin-left: 20px;">Chestertown Maryland</span> <span style="margin-left: 20px;">DATE SIGNED</span> <span style="margin-left: 20px;">2/14/58</span>			
<b>PHYSICIAN'S NAME (Type)</b> <span style="margin-left: 20px;">Thomas J. Solon</span>							
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <span style="margin-left: 20px;">Burial</span>		<b>22b. DATE THEREOF</b> <span style="margin-left: 20px;">2/16/58</span>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <span style="margin-left: 20px;">Fountain Cem.</span>			
<b>22d. LOCATION</b> (City, town, or county) <span style="margin-left: 20px;">(State)</span> <span style="margin-left: 40px;">near Chestertown, Md.</span>							
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <span style="margin-left: 20px;">Kenneth Walley</span> <span style="margin-left: 20px;">ADDRESS</span> <span style="margin-left: 20px;">Chestertown, Md.</span>				<b>24a. REC'D BY REGISTRAR</b> <span style="margin-left: 20px;">DATE</span> <span style="margin-left: 20px;">FEB 21 '58</span>			
<b>24b. REGISTRAR'S SIGNATURE</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2072141XV5

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		COUNTY		STATE	
JAMES EARL RAY		MALE		35		JAN 5 1928		MOBILE		ALABAMA		ALABAMA		ALABAMA	
MARRIAGE		DATE		PLACE		CITY		COUNTY		STATE		CITY		COUNTY	
MARRIED		JAN 15 1950		MOBILE		ALABAMA		ALABAMA		ALABAMA		ALABAMA		ALABAMA	
OCCUPATION		DATE		PLACE		CITY		COUNTY		STATE		CITY		COUNTY	
CONDUCTOR		JAN 15 1950		MOBILE		ALABAMA		ALABAMA		ALABAMA		ALABAMA		ALABAMA	
CAUSE OF DEATH		DATE		PLACE		CITY		COUNTY		STATE		CITY		COUNTY	
HEART DISEASE		JAN 15 1950		MOBILE		ALABAMA		ALABAMA		ALABAMA		ALABAMA		ALABAMA	
MANNER OF DEATH		DATE		PLACE		CITY		COUNTY		STATE		CITY		COUNTY	
NATURAL		JAN 15 1950		MOBILE		ALABAMA		ALABAMA		ALABAMA		ALABAMA		ALABAMA	
SIGNATURE OF PHYSICIAN		DATE		PLACE		CITY		COUNTY		STATE		CITY		COUNTY	
JAMES EARL RAY		JAN 15 1950		MOBILE		ALABAMA		ALABAMA		ALABAMA		ALABAMA		ALABAMA	
SIGNATURE OF REGISTRAR		DATE		PLACE		CITY		COUNTY		STATE		CITY		COUNTY	
JAMES EARL RAY		JAN 15 1950		MOBILE		ALABAMA		ALABAMA		ALABAMA		ALABAMA		ALABAMA	

BUREAU V. 2

FEB 21 1958

RECEIVED



TO DEPUTY CHIEF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar pending burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02085

2096

1. PLACE OF DEATH a. COUNTY <b>Kent</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Chestertown</b> c. LENGTH OF STAY IN 1b life d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Chestertown</b> d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>David</b> Middle <b>A.</b> Last <b>Whiteley</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>22</b> Year <b>19 58</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 12, 1948</b>	9. AGE (In years last birthday) <b>9</b> yrs.	IF UNDER 1 YEAR Months <b>9</b> Days <b>9</b> Hours <b>9</b> Min. <b>9</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>student</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Kent County</b>	
13. FATHER'S NAME <b>Paul E. Whiteley</b>		14. MOTHER'S MAIDEN NAME <b>Flora M. Dickerson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>none</b>		17. INFORMANT Address <b>Herman Blackway, Chestertown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>Drowning</b> <b>Instantaneously</b> IMMEDIATE CAUSE (a) <b>Was out walking about 2:00P.M. 2/22/58 and was missed</b> 929.8 <b>late afternoon. Search was made. The body was</b> Conditions, if any, which gave rise to immediate cause (b) <b>found under a hole in the ice on a branch of Lankford</b> (a), stating the underlying cause lost. <b>Bay. Death is presumed to have been caused by drowning</b> DUE TO <b>Bay.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Probably fell through a hole in the ice</b>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>late afternoon 2/22/ 19 58</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Lankford Bay</b>	
		20f. (City or town) <b>Chestertown</b>		(County) <b>Kent</b> (State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <b>Robert W. Farr, M. D.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>2/24, 1958</b>	
EXAMINER'S NAME (Type) <b>Robert W. Farr, M. D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 25, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Chester Cem.</b>	
				22d. LOCATION (City, town, or county) <b>Chestertown, Md.</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Wells Wells</b>		ADDRESS <b>Chestertown, Md.</b>		24a. REC'D BY REGISTRAR <b>FEB 26 58</b> 24b. REGISTRAR'S SIGNATURE <b>W. J. Smith</b>	

BUREAU V. S.  
FEB 28 1953

RECEIVED  
FEB 25 1953